

GOVERNOR'S **CHILDREN'S** TASK FORCE

A ROADMAP TO SAFETY FOR NEBRASKA'S CHILDREN

"Cherishing children is the mark of a civilized society." - Joan Ganz Cooney

Prepared for:
GOVERNOR MIKE JOHANNIS

Prepared by:
The Governor's Children's Task Force

December 23, 2003

Table of Contents

Introduction	3
Section 1: Prevention Services	4
Section 2: Screening of Child Maltreatment Reports	7
Section 3: Investigation of Child Maltreatment Reports	8
Section 4: Civil and Criminal Prosecutions	12
Section 5: Caseworker Workload and Retention Issues	14
Section 6: Funding for Implementation	15
Appendix A: Children's Task Force Membership	17
Appendix B: Resource Information	18

Appendix C: Previous Studies and Reports

24

Introduction

Governor Mike Johanns created the Children's Task Force out of concern for an increasing number of violent child deaths that have occurred in Nebraska in recent years. The Task Force was charged with assessing the child protection system, identifying strengths and weaknesses in the system and developing recommendations for improvements aimed at preventing future violent child deaths. The Task Force is comprised of 36 individuals representing various disciplines, areas of expertise and interests. Five meetings were held between October 9 and December 18, 2003. Information about the child protection system was gathered from the public and from professionals who play key roles within the system through a series of public forums and focus groups that were held across the state. Opportunities for public input were also provided during Task Force meetings and through written comments. Altogether 26 meetings were held involving over 500 people.

In addition to the information gathered through the public forums and focus groups, the Task Force relied on the experience and expertise of its members, previous reports that have been published in recent years and a report from the State Child Death Review Team on 30 child maltreatment related deaths that occurred between 1998 and 2003. The Task Force's recommendations are divided into the following four areas: 1) ensuring necessary preventive services exist across the state; 2) child maltreatment reports are screened appropriately so that cases requiring intervention receive appropriate follow-up and attention; 3) child maltreatment reports are investigated in a competent, thorough manner utilizing a coordinated, multidisciplinary approach; and 4) judicial involvement is utilized appropriately for the protection and safety of children.

Child Protective Services within the Department of Health and Human Services is just one part of a very complex system for the protection of children. Improvements are needed in all areas of the system, including improved communication and coordination among all professionals who have a responsibility in the identification, investigation and treatment of child maltreatment.

Some of the recommendations included in this report can be implemented relatively quickly and will result in immediate improvements to the child protection system. However, not all of the problems are so easily accomplished. Some recommendations, particularly those calling for increased funding and changes to existing law, will take more time to complete and will require the steadfast resolve and political courage of the executive, legislative, and judicial branches of government.

The death of any child is tragic. Children are not supposed to die. When the cause of death is attributable to abuse or neglect, the loss is further magnified because it suggests that the community has failed to look after and provide for the safety and well-being of its most vulnerable members. Child protection is a community's responsibility. Community includes the child's family, friends, neighborhood, school, church and doctors and lawyers. The community also includes mandated protective agencies including CPS, law enforcement, county attorneys, guardians ad litem, CASA volunteers, and the court system.

Recommendations in this report include preventive measures that can be put in place in communities as well as specific recommendations to strengthen the formal child protection system and to protect children from maltreatment-related harm or death.

Change for the sake of change is not appropriate. The Task Force strove to identify changes that could reasonably be expected to result in improved results for child safety and child and family well-being. It will be absolutely necessary to monitor implementation to ensure the desired results are being achieved. The Governor should identify a mechanism or body for implementation at the earliest possible date.

The Task Force would like to recognize the commitment and efforts of those who work on the front lines every day for the safety and protection of children. These professionals often come under criticism and rarely receive the recognition they deserve for the important and difficult work they do. It is essential for them to be an integral part of implementation and evaluation of the Task Force's recommendations.

The Task Force would also like to recognize Governor Mike Johanns for taking a proactive approach to addressing the problem of violent child deaths and for his commitment to the safety and well-being of Nebraska's children. Several state senators have also played key roles in the creation and work of the Task Force and their leadership in the Nebraska Legislature will be essential to fully implement the Task Force's recommendations.

Desired Outcome: A continuum of prevention services exists on a statewide basis.

The importance of child abuse prevention efforts cannot be overstated. According to Prevent Child Abuse America, a national advocacy organization, every year more than a million children in the United States are seriously abused by their caretakers, and between two thousand and five thousand children die from abuse. Prevent Child Abuse America recently generated the first national estimates of the annual costs of child abuse and neglect in the United States. That analysis, which includes estimates of the direct or immediate costs of abuse as well as the indirect or long-term costs, suggests that child abuse and neglect costs the nation \$258 million each day, or approximately \$94 billion each year. (Prevent Child Abuse America, 2001).

Most of the efforts to address the problem of child abuse and neglect to date have been focused on identifying abused children and providing them with medical and protective services in the hope that the immediate scars will be eradicated and the abuse will not recur. Without detracting from the importance of helping families in which abuse has already occurred, the Task Force believes it is imperative to invest in services and activities aimed at preventing child abuse before it occurs.

(See Appendix B for additional resource information about prevention services.)

Recommendation 1.1: Implement voluntary universal home visitation services for new parents on a statewide basis.

Research has demonstrated the effectiveness of home visitation services in the prevention of child maltreatment and the promotion of other positive outcomes for children and families. A National Task Force on Community Preventive Services reviewed 21 home visitation studies, two of which were of Healthy Families America programs. Studies reviewed by the Task Force suggest that approximately *40% of maltreatment episodes might be* prevented through programs of early childhood home visits. Both abuse/neglect reports and fatal and non-fatal injuries were reduced. The actual reduction in abuse/neglect may be greater than 40% because the presence of home visitors will increase the likelihood of observing abuse/neglect and injuries. The study found that programs with professional home visitors, such as nurses (48.7% reduction in child abuse) or mental health workers (44.5% reduction) were more beneficial than programs with paraprofessional visitors (17.7% median reduction but some programs showed no reductions.) Research shows that each dollar spent on prevention saves approximately \$8.00 in future intervention costs.

(See Appendix B for additional resource information on home visitation services.)

Recommendation 1.2: Conduct drug screening of newborns and services for follow-up, including treatment programs for mothers.

Drug screening is intended as an early detection mechanism for substance abuse issues and as an opportunity to connect the mother and other caretakers with appropriate treatment programs rather than as a punitive measure. It will be important to have community-based, family-centered substance abuse treatment services available for parents. In addition to core substance abuse treatment and recovery services, other essential support services should be provided to assist the mother and other caretakers in recovery.

Recommendation 1.3: Encourage the State Department of Education to require child abuse prevention education to be part of the curriculum in public and private schools.

The majority of child death cases reviewed by the Child Death Review Team for the purposes of the Task Force's work, involved young perpetrators under the age of 25. Of the 30 child deaths reviewed, six children died from shaken baby syndrome and eleven children died from blunt force trauma or head trauma. Too many young people become parents or are placed in situations where they are required to care for children without adequate training or preparation to handle the responsibility, especially crying infants and toilet training accidents.

Recommendation 1.4: Conduct public service announcements on various topics, i.e. shaken baby syndrome, co-dependency, dangers of leaving children with substance abusing adult (in particular meth users), etc.

As a chartered chapter of Prevent Child Abuse America, Prevent Child Abuse Nebraska has access to a variety of materials that have been developed to educate the public about child

maltreatment. Prevention materials have also been developed by other local, state and national organizations. It will be important for Prevent Child Abuse Nebraska, the Child Abuse Prevention Fund Board, Voices for Children, the Department of Health and Human Services, the Nebraska Medical Association and other organizations with an interest in child abuse prevention to work together on a public awareness/education campaign.

(See Appendix B for additional information on public education and awareness activities.)

Recommendation 1.5: Oversight of the State Child Death Review Team's review of child maltreatment related deaths should be assigned to an agency that does not have a potential conflict of interest in the outcome of the review. A process for local child death reviews should be instituted under the administration of the State Attorney General's Office.

More details regarding these recommendations follows:

- **State Level Review:** A subcommittee of the State Child Death Review Team (CDRT), chaired by the Lieutenant Governor, should review child maltreatment related deaths. The subcommittee should include a pediatrician with expertise in child maltreatment and mental health and/or substance abuse professionals who are not associated with the Department of Health and Human Services. State and local review of serious injury and near fatality cases should be explored.
- **Local Review:** The Attorney General's Office should be given responsibility and authority to convene a local multidisciplinary team to conduct a review of child maltreatment related deaths within 30 days of a child's death. All agencies having relevant information regarding the child or the family should be required to share such information for the purposes of the review. Local reviews should be conducted according to criteria established by the State CDRT. The same laws governing confidentiality that the State CDRT operates under should apply to the local review teams. Information and results collected during the local review should be forwarded to the State CDRT for use in their review process.
- **HHS Internal Review:** For all child deaths where the child was in the custody of HHS or the family had an open service case within the past two years, the Department should conduct an internal review of the handling of the case within 30 days of the child's death and forward its findings and action taken to the Governor.

(See Appendix B for additional resource information on the State Child Death Review Team.)

Recommendation 1.6: Mandatory training on child maltreatment for professionals who work with children and who are licensed to practice in the State of Nebraska.

Professionals who work with children are in a unique position to identify child maltreatment. Mandatory training is essential to ensure they have the necessary knowledge to identify and report suspected child maltreatment.

Recommendation 1.7: Expand mental health treatment for children and youth to ensure early identification and treatment of problems.

Advances in infant and toddler mental health research and practice indicate that very young neglected and abused children suffer significant disruptions to their emotional, cognitive and physical development. Family-focused mental health services for infants and toddlers who evidence these developmental delays (as identified and referred by physicians, home visitors or child care providers) show considerable promise in addressing parental behavior and in helping the children get back on track developmentally. Further, there is considerable evidence that mental health treatment for victims of abuse is a key factor in breaking the intergenerational transmission of child maltreatment.

Recommendation 1.8: Drug Courts which incorporate treatment in their program should be established locally and be funded by a combination of federal, state and local funds. The use of Family Drug Courts to mandate treatment of all household members should be explored and the development of pilot programs encouraged.

The benefits of a well-administered drug court are well established. The Courts are effective in treating addiction with a resulting benefit to children of addicts who are reformed by the courts.

Desired Outcome: Child abuse and neglect reports are screened appropriately so cases warranting investigation and possible intervention receive an adequate response.

The Department of Health and Human Services is in the process of implementing a new intake process that is aimed at collecting critical information to improve decision making and to begin assessing the immediate safety of the children involved. Some of the additional information the Department is collecting includes the following: Domestic Violence; Substance Abuse; Mental Health; all prior abuse/neglect history; collateral information; and non-custodial parent and relatives.

(See Appendix B for additional resource information on the screening of child abuse and neglect reports.)

Recommendation 2.1: Child maltreatment reports involving children under the age of 6 are given priority for a response.

The State Child Death Review Team reviewed 30 maltreatment related deaths for the Children's Task Force. Out of the 30 deaths reviewed, 25 of the victims were under the age of 5.

Recommendation 2.2: State law should be amended to require CPS and law enforcement to investigate reports alleging children are in a home where they witness domestic violence or

children are in a home where drugs are used, manufactured, or available to the children. HHS policy regarding domestic violence and substance abuse allegations should be changed accordingly.

In a significant number of the child deaths that were reviewed by the Child Death Review Team, substance abuse and/or domestic violence were identified as issues within the families. Seventeen of the individuals directly responsible for the child's death had significant histories of alcohol or drug abuse. Eight of the individuals had used or had a history of using the drug methamphetamine. Three individuals used methamphetamine within 24 hours, or were actually under the influence at the time of the child's injury.

Nebraska law should be amended to reflect current knowledge that exposure of children to domestic violence is harmful and constitutes child abuse. Domestic violence was identified as either a direct factor or part of the family's history in 46% of the child death cases studied. Of all of the information found by the Child Death Review Team, domestic violence was one of the most common occurring related factors. This is consistent with national figures that indicate domestic violence is the single most predictive factor for child abuse. It will be important to include domestic violence professionals in discussions about how to protect children who are in homes where domestic violence is occurring. The Domestic Violence Coordinating Council of Omaha may be a good model of a multidisciplinary council that brings people to the table to talk about ways to support and empower the mother while ensuring the safety and protection of the child.

Desired Outcome: Child maltreatment reports are investigated in a thorough, competent manner utilizing a coordinated, multidisciplinary approach.

Across professional disciplines and among national child welfare experts, a joint, collaborative approach to investigating child maltreatment by law enforcement and child protective services is seen as the preferred approach. An obvious advantage of this approach is that it results in the best assessment of the family's situation which leads to better decisions about what is needed for the safety and protection of the child. Another advantage of a collaborative approach is that it focuses the best available resources for the benefit of the child and family.

Nebraska's child protection system has all of the necessary components for a collaborative approach to investigating child maltreatment. However, additional mechanisms need to be put in place and additional resources committed to help the system function more effectively. We cannot continue with the practice of unfunded mandates and expect the system to continue to do more with less. It is time to fully fund the responsibilities of the child protection system and then to hold it accountable.

The recommendations that follow should be implemented immediately to address the problems the Task Force identified with the investigation of child maltreatment reports. It will be important to monitor implementation to ensure the desired results are achieved.

Adjustments should be made as needed based on evaluation of the results and new knowledge gained through research and practice.

(See Appendix B for additional resource information on a multidisciplinary approach to the investigation of child maltreatment reports.)

Recommendation 3.1: Clarify the respective roles of CPS and law enforcement in the investigation of child maltreatment reports with well-delineated mechanisms for accountability and follow through on investigations.

Nebraska Statutes currently give both CPS and law enforcement responsibility for the investigation of child maltreatment reports. Nebraska Statutes should be revised to include the following descriptions of the respective roles of CPS and law enforcement:

Child Protective Services: Child Protective Services has expertise in conducting assessments of children and families and in making decisions about child and family needs. The primary responsibility of CPS in the investigation of child maltreatment reports is to ensure the ongoing best interests, safety and protection of a child from foreseeable danger, including the coordination of services to strengthen the family unit and prevent, intervene, and treat child maltreatment.

Law Enforcement: Law enforcement has expertise in conducting criminal investigations and in the collection and preservation of evidence. The role of law enforcement in investigating allegations of child maltreatment is that of an objective fact finder. It is law enforcement's responsibility to determine if a crime has occurred; gather and preserve physical and testimonial evidence; assess child safety issues and initiate emergency protective custody of children in imminent danger of harm; and apprehend the individual responsible for the criminal act.

Recommendation 3.2: Expand the availability and utilization of Child Advocacy Centers.

There are currently six Child Advocacy Centers (CACs) in Nebraska located in Scottsbluff, Kearney, Grand Island, Norfolk, Lincoln and Omaha. The Omaha and Lincoln CACs are accredited through the National Children's Alliance and the Scottsbluff and Kearney CAC's have achieved associate status with the Alliance. The Grand Island and Norfolk CACs are working towards accreditation.

CACs play an important role in the investigation of cases involving allegations of sexual abuse, physical abuse, children coming out of a methamphetamine lab, and children who witness violence by providing a safe and neutral environment for medical exams and for child interviews, thereby reducing the need for multiple interviews that may re-traumatize and re-victimize the child. Currently, Nebraska's CACs must rely on private donations as their primary source of funding. It is time for the state to step up to the plate and become a significant funding partner to support the critical role CACs play in the investigation of child maltreatment.

(See Appendix B for additional resource information on Child Advocacy Centers.)

Recommendation 3.3: Require coordinated investigations by CPS and law enforcement.

When CPS and law enforcement coordinate the investigation process, the civil and criminal investigations of child maltreatment can occur at the same time, which saves time for both agencies and minimizes intrusion for the family. Nebraska currently uses a model where law enforcement has primary responsibility for the investigation of child maltreatment reports. (It should be noted that this model for investigation is used in less than ten other states.) In this model, Child Protective Services' responsibility is triggered, usually after the law enforcement investigation, if services and/or placement are warranted. Law enforcement also makes decisions about whether the child should be removed from the home and carries out those functions. Follow-up by CPS following the law enforcement investigation is discretionary even though such follow-up may be appropriate and necessary to assess the safety of the child and to arrange/provide services to reduce the risk of future maltreatment. This results in some cases falling through the cracks. Nebraska Statutes should be changed to require law enforcement and CPS to conduct joint investigations in cases where the initial report, if true, would constitute a felony and to require follow-up by CPS to ensure that in every case of suspected child abuse or neglect, an appropriate safety assessment has been conducted.

Recommendation 3.4: Facilitate and enhance the exchange of information between law enforcement and CPS through a shared data base that can be accessed by both parties and through clearer statutory provisions for the mandated sharing of information relevant to child abuse and neglect investigations.

The ability to share information between agencies and across jurisdictions is essential to a coordinated investigation process. Information sharing provides all involved agencies with a clearer picture of the child and family and their history with both law enforcement and CPS and results in all agencies being able to respond more quickly and appropriately to the child and family. Having a shared data base between CPS and law enforcement will facilitate the sharing of information and help ensure professionals conducting investigations have the full history on the family that is the subject of a report.

Nebraska law should be amended to remove any ambiguity in the sharing of information between CPS and law enforcement. All child abuse and neglect cases reported to the Department of Health and Human Services should be sent to the appropriate law enforcement agency within twenty-four hours of receipt by HHS and all cases reported to law enforcement should be sent to the Department of Health and Human Services within twenty-four hours of their receipt by law enforcement. Both CPS and law enforcement should be required to share all child abuse and neglect reports with the local Child Advocacy Center they are affiliated with within twenty-four hours of receipt of report.

Most states maintain a centralized data base of substantiated child abuse cases to track repeated reports on the same family and to identify families that move from one community to another. A similar data base is needed on a national level to identify families who move

from one state to another. Nebraska should work collaboratively with other states and with federal officials to develop a National Child Abuse Registry.

Recommendation 3.5: Require a multidisciplinary approach to the investigation of child maltreatment reports by strengthening the LB 1184 teams through funding for coordination, training and operating expenses for teams.

Accountability of the agencies charged with responsibility for investigating child maltreatment reports was of significant concern to Task Force members. A multidisciplinary approach involving the timely sharing of information between agencies and joint decision making is one way of assuring accountability. A paid coordinator functioning in a neutral capacity can facilitate communication between agencies and track cases as they move through the system. Having a neutral entity play this coordinating role provides further assurance that children will not fall between the cracks.

A core component of a multidisciplinary approach to the investigation of child maltreatment are team meetings that draw staff from many agencies and professional disciplines together for information sharing and joint decision making about what is most appropriate for a child. Multidisciplinary teams go hand-in-hand with Child Advocacy Centers (CACs). CACs provide a neutral forum to bring professionals to the table to discuss cases and to work through any problems that occur on either a case specific or system level. It is common practice for multidisciplinary teams to meet at a CAC if one exists in the community.

Nebraska already has a mechanism in place for a multidisciplinary approach to the investigation and treatment of child maltreatment through LB 1184 which was passed by the Nebraska Legislature in 1992. Every county or contiguous group of counties in the state are required to have an investigation and treatment team. The county attorney is required to convene the team and teams are required to meet at least quarterly and to develop protocols for how child maltreatment cases will be handled.

Unfortunately, inadequate funding and lack of staff support have been barriers to full implementation of this legislation. Approximately two thirds of Nebraska counties report having a team in place. Counties with functioning teams report that it has helped to improve communication, coordination and working relationships among the agencies responsible for the investigation and treatment of child maltreatment. Counties report that those improvements resulted in faster, higher-quality investigations which caused less trauma to children.

The Task Force recommends building on the success of existing teams and providing the necessary resources and support to have all counties in Nebraska served by a multidisciplinary team. To accomplish this goal, the Task Force recommends that CACs be used as a central coordinating agency wherever feasible and that funding be provided to CACs for paid staff to coordinate team activities. CACs should work with the Center on Children, Families and the Law at the University of Nebraska to provide training and technical assistance to teams. (The Center on Children, Families and the Law has intermittently, as funding permitted, operated a resource center to provide a minimal level of

financial and technical support to the teams through federal funding provided by the Department of Health and Human Services.)

It should be noted that the Task Force is very concerned about the failure of many county attorneys to convene teams even though they are required to be state law. The Task Force recommends that the Legislature consider various options for holding county attorneys accountable for implementing this key piece of legislation.

Recommendation 3.6: Facilitate communication and coordination between CPS and law enforcement agencies through co-location in urban areas and to the extent possible in rural areas of the state.

Co-location of CPS and law enforcement has already been achieved in Omaha. Both agencies are located at Project Harmony which is a Child Advocacy Center. Steps should be taken to co-locate CPS and law enforcement in Lincoln, as well, in conjunction with Lincoln's Child Advocacy Center. Co-location of CPS and law enforcement should be explored in other communities in Nebraska, as well.

Recommendation 3.7: Increase the capacity of law enforcement professionals to investigate child maltreatment reports through increased training.

Some law enforcement officers do not have the specialized expertise that is needed to respond to child abuse and neglect; more training is needed for these professionals. The number of hours of training contained in the current curriculum used by the Law Enforcement Training Center for the initial training of law enforcement officers is woefully inadequate. Additional upfront training should be required to prepare law enforcement officials for the important and challenging task of conducting child maltreatment investigations. Ongoing training opportunities should be expanded utilizing the Child Advocacy Centers and cross-training provided through the LB 1184 teams. Cross-training is essential so that personnel from each agency understand the other agency's role and responsibilities and exactly how to collaborate to coordinate investigations. The use of technology is encouraged to maximize participation by law enforcement officials in rural areas of the state.

Desired Outcome: Adequate civil and criminal prosecutions and informed adjudications needed for the safety and protection of children and children receive special treatment by the courts during litigation.

The Task Force received a plethora of information from many sources that the prosecution and adjudication of child welfare cases frequently is inadequate and sometimes harmful to children. Some of the inadequacies were due to untrained and over-burdened and under-funded prosecutors and judges. At the public hearings, people complained that prosecutorial decisions on filing civil and criminal cases were inconsistent throughout the state. Prosecutors opined they lacked funds to hire experts necessary to prove their cases. Other witnesses stated that some district judges were authoritarian, uncaring and seemed to be more

interested in hearing cases other than dissolution and custody matters, even though these cases make up about half the cases filed in the district courts of the state. Litigants and those related to litigants said some judges refused to hear live testimony preferring instead to take evidence by affidavit.

Recommendation 4.1: The legislature must restore the Crimes Against Children Fund as quickly as possible.

Last session the legislature cut the biennial \$68,000 Crimes Against Children Fund which is administered by the Crime Commission and assists county attorneys in hiring expert witnesses to prove allegations in both civil and criminal cases throughout the state.

Recommendation 4.2: The Office of the Attorney General should be given the responsibility for handling all juvenile court cases for abuse, neglect and termination of parental rights cases in all jurisdictions where there is no established Separate Juvenile Court. In jurisdictions having a Separate Juvenile Court, such responsibility should be retained by the elected county attorney.

It is the strong recommendation of the Task Force that assistant attorneys general working with fully equipped non-profit child advocacy centers where child protection workers and law enforcement officers are co-located (to the extent possible) offer the strongest possibility to create an effective investigative team to protect children. This investigative model has proven effective in drug enforcement and should be the lynchpin of child welfare reform. Well-trained prosecutors directing a joint response to reports of serious child abuse by a team of tenacious and experienced investigative professionals seems to be the answer to many of the problems the Task Force uncovered. These reconstructed LB 1184 teams must have resources to be successful. Experienced attorneys and investigators interested in protecting kids must be paid well and accorded respect to be retained. Currently many prosecutors are usually just out of law school with little or no legal or life experiences. The turnover in rural child (and some urban) CPS workers and law enforcement officers typically produces inadequate or incomplete investigations. This level of attention to child welfare litigation must change so that our children can be protected. It should be noted that in some rural areas it may be necessary to assign state patrol investigators to the teams due to a serious shortage of law enforcement officers or low population density.

Recommendation 4.3: Guardians ad Litem should be trained, accredited and required to certify to the court they have visited children they represent.

The Task Force has considered the benefits of guardians ad litem. They are the eyes and ears of the court. It is the opinion of the task force that the professional associations of the juvenile, county and district judges study and recommend to the Nebraska Supreme Court a system of rules which will enhance the professionalism of guardians. These rules should specify training, caseload restrictions and reporting requirements of guardians ad litem. The task force believes every guardian should visit a child he or she represents at least once a month and that no guardian should be paid who has not made such visits.

Recommendation 4.4: Court Appointed Special Advocate (CASA) programs should be coordinated by state funded coordinators.

The Task Force found that CASA programs are some of the most helpful and least assisted child protection programs in the state. The CASA volunteers act as a special voice and friend to children in court. Volunteers cost the state nothing, but to assist in finding and training new volunteers and retaining old ones, the state should fund coordinators whose responsibility it is to accomplish this important task.

Recommendation 4.5: The Supreme Court should undertake a study in conjunction with the Nebraska Bar Association (NSBA) to determine 1) to what extent the current judicial system is insensitive to children and 2) whether the establishment of a Family Court system is in the best interest of children of the state and its citizens.

The Supreme Court and the NSBA are in a unique position to undertake a study of the Nebraska courts to determine whether they are hostile, unfriendly and ambivalent about the welfare of children. These agencies have undertaken such studies in the past to determine whether the courts were hostile to women and minorities in our system of justice. It seems fitting they should be willing to do the same for children. Time and again the Task Force was told that lawyers and judges are difficult to deal with and lack empathy for children caught in litigation. The Task Force feels the courts should study the issue and take action to correct any deficiencies. The Task Force had no time to explore these issues in any detail, but is compelled to make this recommendation due to the nature and extent of the testimony received.

Desired Outcome: Strengthen the effectiveness of Protection and Safety Staff within the Department of Health and Human Services.

The Task Force found the turnover among CPS workers to be too high. A common complaint of foster parents was that they never knew their caseworker because the workers quit before they got to meet them. It was also noted that many experienced workers were being hired by contractors because the pay was the same or better and there was less stress working for the contractor.

Recommendation 5.1: Increase the number of Protection and Safety Staff to bring caseloads within state standards.

One of the most troubling findings of the Task Force is the heavy caseloads CPS workers are facing today. Caseloads must be brought down so that each child is given the time he or she deserves and so that a child in an unsafe condition is not overlooked.

The Nebraska Department of Health and Human Services issued their "Child Welfare Staffing Summary 2002" report to the Legislature in August 2003. Based on the workload analysis using the Nebraska Recommended Standards (1992) the total additional FTE's

needed was 99.4. The Task Force sees this number as a minimum and notes that this number will likely rise after a thorough, more up-to-date evaluation of the kinds of children and families being served today and the likely increase in the number of accepted intakes with implementation of the new intake tool. The Task Force also urges a comparison of the Nebraska Recommended Standards with standards established by the Child Welfare League of America to ensure our method of counting cases is consistent with recommended practice on a national level.

Recommendation 5.2: The Department of Health and Human Services should expand the hours CPS staff are available.

The Task Force believes the availability of CPS staff to provide coverage 24 hours per day, 7 days per week would facilitate joint investigations with law enforcement and greatly improve the system's response to the needs of children and families. The Department of Health and Human Services should explore all options for providing 24/7 coverage and work with the Governor and the Legislature to ensure the necessary resources are available to accomplish this goal.

Recommendation 5.2: Take the appropriate steps to hire and retain competent Protection and Safety Workers and Supervisors.

The Child Protection System should operate under the philosophy that Protection and Safety Workers (PSWs) and Protection and Safety Supervisors (PSSs) are valued professionals and, therefore, should have professional standards that govern their work. The Task Force makes the following recommendations toward that goal:

- HHS should conduct a salary study for the positions of PSW and PSS using comparable positions in other states and in other agencies within the State of Nebraska. Once the study is complete, the State should endeavor to bring PSWs and PSSs up to a level that peers would be paid.
- Higher pay should also be given to PSWs and PSSs based on education level, job function (Investigation vs. Ongoing Worker), and bi-lingual skills.
- Provide educational incentives for PSW and PSS Supervisors to continue their education to expand their knowledge base and to stay current with research and practice in the field.
- Minimum qualifications for the job of PSW should include at least a Bachelor's degree in a human service field;
- HHS should reinstitute ongoing annual evaluations of workers, a practice that was abandoned by the previous administration;
- A mentoring program for PSWs should be established; and
- HHS should increase opportunities for PSWs to be involved in decision making, especially in regards to policy or procedural changes that effect them.

Recommendation 5.3: HHS should move toward accreditation through the Council on Accreditation for Agencies serving Children and Families (COA).

In addition to assuring a certain level of quality of services provided to children and families, gaining accreditation through COA would help to address issues of accountability that are of

concern to Task Force members. COA worked with the Child Welfare League of America to develop standards for agencies serving children and families. Standards have been developed specifically for public child welfare agencies. Over 100 public child welfare service agencies are accredited, including both state and county run agencies. Areas covered in the accreditation process include Child Protective Services (Intake, Initial Assessment and Family Case Work), Foster Care, Adoption, Intensive Family Preservation and Family Support. Areas related to management are also covered in the accreditation process including Human Resources, Training, Continuous Quality Improvement, Outcomes Management, etc.

Desired Outcome: Secure sufficient funding for the safety and well-being of Nebraska's children.

Recommendation 6.1: Establish the Child Safety Fund.

The Child Safety Fund would be similar to the Highway Trust Fund in that the fund is sacrosanct and will not be used for any other purpose than the Child Protection System. There are many potential sources of funding for this fund: alcohol and/or cigarette taxes, vanity license plates, marriage license tax, redirected funding, etc.

Recommendation 6.2: Ensure the Attorney General's Office has the necessary resources to assume the new responsibilities they will be given through implementation of the recommendations in this report.

Many of the recommendations of this report give the Attorney General's Office more responsibility. It is imperative that the necessary staff and financial resources be given to the Attorney General's Office so they can handle these new duties without it being a burden to that Office.

Our thanks to Cornerstone Printing for their generous contribution.

Appendix A

Children's Task Force Membership

Gary Lacey, Co-Chair, Lancaster County Attorney - Lincoln
Mary Jo Pankoke, Co-Chair, Nebraska Children and Families Foundation- Lincoln

Leroy Adams, Minister - Omaha
Senator Ray Aguilar - Grand Island
Nancy Bare, Education - Lincoln
Rebecca Barrientos-Patlan, Education - Omaha
Stacie Bleicher, M.D. - Lincoln
Lisa Borchardt, Education - Lincoln
Judge Vernon Daniels - Omaha
Camas Diaz, Child Protective Services - Omaha
Mary Fraser Meints, Children's Treatment Services - Omaha
Paco Fuentes, Children's Services - Omaha
Carmen Gottschalk, Foster Parent - Omaha
Rebecca Harling, Lincoln County Attorney - North Platte
Kim Hawekotte, Douglas County Attorney's Office, Juvenile Division - Omaha
Judge John Icenogle - Kearney
Judge Robert Ide - Holdrege
Lee Jacobsen, Nebraska State Patrol - Kearney
Maria Lavicky, Child Protective Services - Lincoln
Steve Lazoritz, M.D. – Pediatrician - Omaha
Vicky Moreno, Special Investigator - Gering
Rick Moses, Child Protective Services - Kearney
Tom Poulton, M.D. - Omaha
Ron Ross, Director, Health and Human Services - Lincoln
Herb Spears, Assistant Attorney General - Lincoln
Marcia Spilker, Education - Beatrice
Carol Stitt, Executive Director, Foster Care Review Board - Lincoln
Senator Arnie Stuthman - Platte Center
Doug Warner - Scottsbluff County Attorney - Gering
Jerry Watson, Hall County Sheriff - Grand Island
Brian Wilcox, Research and Data - Lincoln
Reggie Young, Attorney - Omaha

Resource Staff

Todd Reckling, HHS Protection and Safety Administrator - Lincoln
Gail Steen, HHS Protection and Safety Legal Team - Lincoln
Vicky Weisz, Center on Children Families and the Law
Richard Wiener, UNL Law & Psychology Department

Appendix B

Resource Information for Outcomes and Recommendations

Desired Outcome: A continuum of prevention services exists on a statewide basis.

The following information was taken from a report published by the United States Department of Health and Human Services entitled *Emerging Practices in the Prevention of Child Abuse and Neglect*.

Existing Framework for Prevention in the Field of Child Maltreatment

With respect to human services, prevention typically consists of methods or activities that seek to reduce or deter specific or predictable problems, protect the current state of well-being, or promote desired outcomes or behaviors (adapted from Bloom, 1996). Professionals working to prevent child abuse and neglect have “borrowed” from other disciplines, including public health, education, and mental health. Though all these disciplines influence and guide practice, perhaps public health has had the greatest influence in organizing a framework of prevention services. That framework consists of three levels of services: *primary* prevention programs, which can be directed at the general population (universal); *secondary* prevention programs, which are targeted to individuals or families in which maltreatment is more likely (high risk); and *tertiary* prevention programs, targeted toward families in which abuse has already occurred (indicated).

Primary prevention activities can be directed at the general population and attempt to stop the occurrence of maltreatment. All members of the community have access to and may benefit from services directed at the general population. Primary prevention activities with a universal focus seek to raise the awareness of the general public, service providers, and decision-makers about the scope and problems associated with child maltreatment. Universal approaches to primary prevention might include:

- Public service announcements that encourage positive parenting;
- Parent education programs and support groups that focus on child development and age-appropriate expectations and the roles and responsibilities of parenting;
- Family support and family strengthening programs that enhance the ability of families to access existing services, resources and support interactions among family members; and
- Public awareness campaigns that provide information on how and where to report suspected child abuse and neglect.

Secondary prevention activities with a high-risk focus are offered to populations that may have one or more risk factors associated with child maltreatment, such as poverty, parental substance abuse, young parental age, parental mental health concerns, and parental or child disabilities. Programs may direct services to communities or neighborhoods that have a high incidence of any or all of these risk factors. Approaches to prevention programs that focus on high-risk populations might include:

- Parent education programs located, for example, in high schools that focus on teen parents, or within substance abuse treatment programs for mothers and families with young children;
- Parent support groups that help parents deal with their everyday stresses and meet the challenges and responsibilities of parenting;
- Home visiting programs that provide support and assistance to expecting and new mothers in their homes;
- Respite care for families that have children with special needs; and
- Family resource centers that offer information and referral services to families living in low-income neighborhoods.

Tertiary prevention activities focus on families where maltreatment has already occurred (indicated) to reduce the negative consequences of the maltreatment and to prevent its recurrence. These prevention programs may include services such as:

- Intensive family preservation services with trained mental health counselors that are available to families 24 hours per day for a short period of time (e.g., 6-8 weeks);
- Parent mentor programs with stable, non-abusive families acting as “role models” and providing support to families in crisis;
- Parent support groups that help parents transform negative practices and beliefs into positive parenting behaviors and attitudes; and
- Mental health services for children and families affected by maltreatment to improve family communication and functioning.

Distinctions between primary, secondary, and tertiary prevention, while perhaps useful for some purposes, do not necessarily reflect the way prevention-related services are actually organized and provided on the ground. Rather than sorting prevention initiatives into mutually exclusive categories, prevention is increasingly recognized as a continuum.

Recommendation 1.1: Implement voluntary universal home visitation services on a statewide basis.

The following information is an excerpt from the federal report entitled *Emerging Practices in the Prevention of Child Abuse and Neglect*.

Home Visitation Programs

Home visitation programs have existed in the United States since the late 19th century. As a strategy for preventing child maltreatment, home visitation came to the forefront of the national agenda in 1991 when the U.S. Advisory Board on Child Abuse and Neglect recommended universal implementation of home visitation programs. Rather than a specific program or activity, home visitation is a strategy for service delivery. Many organizations and agencies in fields as varied as education, maternal and child health, and health and human services use home visitation programs to strengthen and support families.

Home visitation programs offer a variety of family-focused services to pregnant mothers and families with new babies and young children. Activities offered through home visitation

programs may include structured visits in the family's home, informal visits, and telephone calls that focus on topics such as:

- Positive parenting practices and nonviolence discipline techniques
- Child development
- Availability and accessibility of social services
- Establishment of social supports and networks
- Advocacy for the parent, child and family
- Maternal and child health issues
- Prevention of accidental childhood injuries through the development of safe home environments.

Recommendation 1.4: Conduct public service announcements on various topics, i.e. shaken baby syndrome, co-dependency, dangers of leaving children with substance abusing adult (in particular meth users), etc.

The following information is an excerpt from the federal report entitled *Emerging Practices in the Prevention of Child Abuse and Neglect*.

Public Awareness Activities

Public awareness activities are an important part of an overall approach to address child abuse and neglect. Such activities have the potential to reach diverse community audiences, including parents and prospective parents, children, and community members. In designing prevention education and public information activities, national, State and local organizations use a variety of media to promote these activities, including:

- Public service announcements
- Press releases
- Posters
- Information kits and brochures
- Television or video documentaries and dramas

Through these media, communities are able to promote health parenting practices, child safety skills, and protocols for reporting suspected maltreatment.

One of the largest child maltreatment public awareness initiatives is focused on the prevention of Shaken Baby Syndrome. A national network of State contacts for Don't Shake the Baby was established to ensure that all professionals involved in the care of children (e.g. teachers, physicians, nurses, home visitors, parent educators) became aware of the dangers associated with shaking infants. In addition to professionals, this campaign targeted parents to alert them to the dangers of shaking their babies and to provide information on positive coping skills when caring for a crying infant.

Recommendation 1.5: Oversight of the State Child Death Review Team's review of child maltreatment related deaths should be assigned to an agency that does not have a potential conflict of interest in the outcome of the review. A process

for local child death reviews should be instituted under the administration of the State Attorney General's Office.

The Nebraska Legislature passed legislation in 1993 creating the State Child Death Review Team (CDRT) which is responsible for reviewing all child deaths that occur in Nebraska. Although child death review teams around the country were established originally to identify and prevent child deaths caused by abuse and neglect, Nebraska has opted for a broader death review process that addresses all child deaths from a public health perspective. This public health approach not only addresses the under-reporting of maltreatment-related deaths, but also promotes better understanding and greater awareness of all the causes of child deaths. The focus of the CDRT's work is:

- To develop a better understanding of why our children die;
- To accurately identify and uniformly report the cause and manner of every child death;
- To advise the Governor, Legislature and the public on changes that might prevent future child deaths.

A local review process would augment rather than duplicate the work of the State CDRT. The purposes of the local child death review would include:

- To ensure a thorough investigation of the circumstances and cause of the child's death is completed;
- To identify any omissions or actions on the part of agencies that are part of the child protection system in cases that were known to the system prior to the child's death;
- To review decisions regarding prosecution of persons responsible for the death;
- To identify changes in local policies and/or procedures that could help prevent future child deaths.

Desired Outcome: Child abuse and neglect reports are screened appropriately so cases warranting investigation and possible intervention receive an adequate response.

According to a *National Study of Child Protective Services Systems and Reform Efforts* published by the U.S. Department of Health and Human Services, screening practices are important to many advocates for an improved child protection system. Some suggest that more restrictive screening protocols will result in some cases being overlooked and ultimately in poorer outcomes for children. Others maintain that given the high proportions of screened-in referrals that are found not substantiated, screening should be more stringent. The study identified the following innovations in screening practices among states:

- Using additional tools during screening process;
- Increasing consistency of screening by centralizing screening or using specialized staff;
- Conducting internal audits of questionable screen-outs;
- Educating reporters as to how to report, what criteria to consider, and what options are available to reporters;
- Analyzing data on screened-out referrals to determine patterns of reporting or re-reporting;
- Improving cross-agency and cross-jurisdictional relationships.

Desired Outcome: Child maltreatment reports are investigated in a thorough, competent manner utilizing a coordinated, multidisciplinary approach.

According to a report published by the American Humane entitled *Investigation Models for Child Abuse and Neglect – Collaboration with Law Enforcement*, a joint, collaborative approach to investigating child maltreatment by law enforcement and child protective services is seen as the preferred approach. Prioritizing a collaborative, multidisciplinary approach holds true across professional disciplines, with representatives of social workers, prosecutors, children's attorneys, law enforcement, and child welfare administrators all favoring formal mechanisms for collaboration. Advantages cited by experts for a collaborative approach to investigation of child maltreatment include:

- *Law enforcement expertise* – Law enforcement is viewed as expert in conducting criminal investigations and in the collection and preservation of evidence.
- *Child protective services/social work expertise* – Child protective services is also viewed as having specialized expertise in working with families and children. The role of child protective services in child and family assessment, in making decisions about child and family needs, and in providing appropriate services to address those needs is acknowledged by all.
- *Other professional expertise* – Collaboration with other disciplines that grows out of law enforcement-child protective services cooperation is also acknowledged as valuable.
- *Effectiveness of partnership* – Mechanisms that allow for child protective services-law enforcement collaboration also reinforce the benefits of a team approach in general. A team approach promotes success intervention through the provision of a full range of services: child protective services to perform risk assessment, make sure the child is safe, and reduce any further risk to child; law enforcement to determine if a crime has been committed and conduct criminal investigation of the case; mental health to provide services to the parents and child; medical services to provide treatment and to gather forensic evidence if appropriate; and prosecution to hold offenders accountable. Without all of these organizations involved, successful intervention is difficult.

The consensus of national experts is that it is helpful to have formal policies, procedures, and mechanisms for collaboration in place to support a collaborative model for investigating child maltreatment reports. Memorandums of understanding, Child Advocacy Centers, and multidisciplinary teams all contribute to a collaborative approach to the investigation of child maltreatment.

Recommendation 3.2: Expand the availability and utilization of Child Advocacy Centers.

The growth of Child Advocacy Centers (CACs) in the United States has been extraordinary. These innovative programs work to improve child abuse investigations and reduce stress on children and families. CACs aim to eliminate repetitive interviews for child victims, provide a child-friendly environment for the investigation, use well-trained interviewers, and coordinate forensic investigations by multiple agencies. The first CAC, the National Children's Advocacy Center, was established in Huntsville, Alabama, in 1985, but CACs have increased from 50 registered centers in 1994 to more than 460 full or associate centers in 49 states in 2003. Even where CACs have not been established, there are programs that

follow many of the same principles and program models as CACs, but have not yet affiliated with the National Children's Alliance, the national membership organization of CACs.

The CAC philosophy draws from a core set of beliefs that the intervention system should respond to the individual needs of the alleged child victim and family and that the most effective response builds upon the expertise of multiple agencies. The original function of CACs was primarily to respond to cases of child sexual abuse. Most CACs today have broadened their target population to include suspected child victims of serious physical abuse, child witnesses to domestic violence, and children affected by other forms of victimization. To be accredited by the National Children's Alliance, CACs must meet the following standards:

- **Child-Appropriate/Child-Friendly Facility:** A comfortable, private, child-friendly setting that is both physically and psychologically safe for clients.
- **Multidisciplinary Team:** A multidisciplinary team for response to child abuse allegations that includes representation from the following: law enforcement, child protective services, prosecution, mental health and medical providers, victim advocacy services, and a children's advocacy center.
- **Organizational Capacity:** A designated legal entity for program and fiscal operations has been established.
- **Cultural Competency and Diversity:** Promotes policies, practices, and procedures that are culturally competent.
- **Forensic Interviews:** Forensic interviews are conducted in a manner that is of a neutral, fact-finding nature and coordinated to avoid duplicative interviewing.
- **Medical Evaluation:** Specialized medical evaluation and treatment are made available to CAC clients.
- **Therapeutic Intervention:** Specialized mental health services are made available as part of the team response.
- **Victim Support/Advocacy:** Victim support and advocacy are made available through the team response.
- **Case Review:** Team discussion and information sharing regarding the investigation, case status and services needed by the child and family occur on a routine basis.
- **Case Tracking:** CACs develop and implement a system for monitoring case progress and tracking case outcomes for team components.

Appendix C

Previous Studies and Reports

- LR 367, 1990 (Available in hard copy)
- Status Report of the Nebraska Commission for the Protection of Children, 1992 (Available in hard copy)
- “Making the Good Life Even Better for Children” A Blueprint to Improve Nebraska’s Response to Child Abuse and Neglect, 1999 (Available in hard copy)
- Nebraska Family Portrait, 2001 (<http://www.hhs.state.ne.us/jus/portrait/execsumm.htm>)
- Final Report of the Children and Family Services Review Findings, 2002 (<http://www.acf.dhhs.gov/programs/cb/cwrp/staterpt/ne/ne.pdf>)
- Program Improvement Plan Narrative and Matrix, 2003 (<http://www.hhs.state.ne.us/jus/portrait/pip/pipindex.htm>)